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CONFERENCE ABSTRACT

Integrated Care in Practice: A Novel Approach

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Introduction: The current care pathway for frail patients in the UK in need of assessment is often into hospital, usually through accident and emergency and then onto a variety of wards.

We have an excellent award winning proactive elderly care team in reach service but it can be several days before a comprehensive geriatric assessment (CGA) is commenced. Length of stay can be prolonged and some patients are left 'stranded' in hospital.

It was felt that a change to the frailty pathways across multiple organisations was needed. A collaboration between the CCG, Lancashire Care Foundation Trust and Lancashire Teaching Hospitals NHS Foundation Trust was initiated.

Practice Change and Implementation: 2 new services have been offered primarily to GP's as an alternative to the inefficient pathway described above:

1- A community based frailty assessment service (FAS) to provide an alternative to acute admission for GPs with patients aged 75+ identified as potentially frail using the Rockwood and Bournemouth criteria.

2- A hospital based acute frailty unit (AFU). Based at the heart of the hospital it aims to admit frail patients directly from the community. It is especially for the more unstable frail patients who may have been excluded from FAS.

Aim and theory of change: Our aim is provide excellent, efficient and timely CGA for frail patients. This will lead to reduction in acute admissions, reduced length of stay if admission is unavoidable and a reduction in re-admissions.

The community based FAS is, as far as we know, totally unique and innovative to the UK. It is untested but existing evidence has been extensively incorporated into its design (eg frailty scores, CGA models, PECT model).

The AFU will complement FAS so that more unwell frail patients are not excluded from CGA and care plans. The theory used to implement both of these new services are based on our well established and successful PECT service.

Targeted populations and stakeholders: We will initially target the over 75's and we will use frailty criteria to identify these patients.

Our main stakeholders are the patients and their families/carers, our GP's, social services, North West ambulance service, the CCG, LCFT and the acute hospital Trust.

Timeline: FAS commenced 28th November 2016, AFU intends to start imminently. Both units hope to be fully operational by early 2017 with initial results available likely March 2017.

Highlights: Highlights include all 3 main service providers collaborating to initiate new services specifically to improve frailty pathways.

Sustainability: Both new services are starting off small and expand as staffing and resources allow

Transferability: AFUs are already well established across the UK but the community FAS is a new concept. We envisage that both services will complement each other, and this model should be easily transferable across the UK.

Conclusions and Lessons Learnt: We envisage a truly integrated care pathway for patients with frailty across the local health economy. Collaborative working can lead to innovation and the delivery of new and high quality services.

Keywords: novel; collaborative; frailty; community; flow
